REIMBURSEMENT CODING SERIES

Code No.	Class Title	Occ. Area	Work Area	Prob. Period	Effective Date
4839(3294)	Reimbursement Coding Specialist I	02	445	6 mo.	06/01/00
4840(3294)	Reimbursement Coding Specialist II	02	445	6 mo.	06/01/00
4841(2451)	Reimbursement Coding Specialist III	03	445	6 mo.	06/01/00

Promotional Line: 166

Series Narrative

Positions assigned to these classifications are professional coders responsible for coding of patient services provided in health care units. Lower level specialists are training level specialists involved in the routine day-to-day coding. Intermediate level specialists perform complex coding in addition to auditing and analysis of coding related activities. The top level is responsible for the overall coding operations of a large unit. All levels must demonstrate proficiency in coding and must be knowledgeable of the requirements of industry standards such as Medicare and/or Managed Care regulations and the International Classification of Disease (ICD-9) and the Current Procedural Terminology (CPT) systems of coding. Reimbursement Coding Specialist IIIs are responsible for monitoring changes in coding procedures as dictated by third-party payors and governmental reform. The higher level also recommends processing standards and teaching coding of diagnoses and procedures to the lower levels of this series as well as clinical staff to maximize reimbursement while adhering to ethical practices and third party payor guidelines.

DESCRIPTIONS OF LEVELS OF WORK

Level I: Reimbursement Coding Specialist I 4839(3294)

Employees at this level are entry-level coders functioning under the direct supervision of a Reimbursement Coding Specialist II or III. Level I employees are training positions and are involved in the routine day-to-day coding and associated work.

A Reimbursement Coding Specialist I typically –

1. assigns codes for ancillary and physician services using standardized coding systems such as ICD-9-CM and CPT, or verifies coding performed by clinical staff for accuracy

2. performs simple analysis of payment patterns in a smaller department having fewer clinical specialties

3. prepares simple reports to illustrate reimbursement rates

4. attends coding and diagnosis seminars

5. may update fee schedules under the direction of supervisor

6. composes simple correspondence to third party payors to resolve billing/charge problems

7. performs other related duties as assigned

Level II: Reimbursement Coding Specialist II 4840(3294)

Employees at this level code physician and ancillary medical services for the purposes of receiving maximum allowable reimbursement from payors. They also perform other coding related functions such as training, research of coding issues, and auditing coding transactions. They function under the general supervision of a Reimbursement Coding Specialist III or related personnel.

A Reimbursement Coding Specialist II typically –

1. codes complex charge documents for ancillary and physician services using standardized coding systems such as ICD-9-CM and CPT, or verifies coding performed by clinical staff and lower level coders for accuracy

2. determines actions such as submissions of additional documentation on individual claims to increase reimbursement levels and provide additional/supplementary documentation needed for payor consideration of non-routine charges

3. interacts with physicians, ancillary personnel and third-party payors to resolve problems with specific charges

4. maintains and updates fee schedules

5. conducts audits of documentation in order to verify accuracy of codes, dates of service, and assure documentation support codes; processes physician's services as needed

6. recommends changes in coding procedures and routinely monitors and investigates the impact of coding on insurance reimbursement

7. composes complex or sensitive correspondence to third-party payors to resolve charge/billing problems

8. may analyze payment patterns

9. prepares complex reports illustrating reimbursement rates

10. as directed by supervisor, researches and assists in the development of policies and procedures related to the coding of physician services using the ICD-9-CM and CPT

11. performs periodic reviews of department charge tickets and researches needed changes; recommends needed changes to appropriate supervisor; researches and reports policy changes mandated by federal and state reimbursement programs

12. may train lower level employees in this series

13. may supervise lower level staff members of small units including interviewing, hiring, evaluating and disciplining; in large units, may assist the Reimbursement Coding Specialist III in these duties

14. performs other related duties as assigned

Level III: Reimbursement Coding Specialist III 4841(2451)

Employees at this level work under administrative direction from a designated supervisor and manage, direct and monitor all coding activities for physician and ancillary services in a unit. They are responsible for performing studies and recommending both unit and institutional standards of reimbursement, fee structure, billing and other medical receivable issues to appropriate personnel. They supervise activities and direct personnel responsible for the coding of charge documents.

A Reimbursement Coding Specialist III typically –

1. develops policies and procedures related to coding of services incorporating applicable legal/ethical/institutional standards

2. performs complex studies of third-party reimbursement patterns involving multiple physicians and fee structures and provides recommendations to physicians or administrators based on findings

3. may prepare complex reports detailing third party reimbursement rates

4. conducts seminars for physicians, residents, administrators and staff on ICD-9-CM and CPT coding, third-party payor submission and billing as it affects timely and effective reimbursement

5. provides expert advice and guidance to administrators, faculty and staff regarding coding, documentation and other third party payor regulations

6. researches and keeps abreast of policy changes mandated by state and federal reimbursement programs; notifies affected personnel on a routine basis

7. researches reimbursement issues related to new services and complete feasibility studies; writes correspondence to third-party payors

8. develops fee schedules for new and existing services provided by the department for approval by physicians and administrators

9. reviews newsletters and the *Federal Register* on a routine basis; issues notifications to physicians and appropriate personnel regarding changes in reimbursement

10. investigates low reimbursement of patient services by third-party payors such as managed care contract reimbursement analysis; performs complex analysis of findings and recommends changes to administrators and physicians

11. may represent department and unit in the development of institutional coding policies and procedures

12. supervises lower level staff including hiring, evaluating, disciplining and interviewing

13. performs other related duties as assigned

MINIMUM ACCEPTABLE QUALIFICATIONS REQUIRED FOR ENTRY INTO:

Level I: Reimbursement Coding Specialist I 4839(3294)

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. (A) 9 semester hours of college credit for course work in medical terminology, anatomy, physiology, health information, or other closely related fields

or

(B) 9 months of responsible work experience involving applied use of the field(s) mentioned in A above

or

(C) any combination of the above that totals 9 semester hours/months

2. (A) 12 semester hours of college credit for course work directly related to medical finance that included 6 semester hours in medical records coding

or

(B) 12 months of health care experience in coding, using ICD-9 and CPT coding systems

or

(C) any combination of the above that totals 12 semester hours/months and included 6 semester hours/months in the coding area

NOTE: Designation as CPC Apprentice, CPC-H Apprentice or Certification as an RHIT by the American Health Information Management Association satisfies all the requirements for this class. (Certification at higher levels, such as an RHIA by AHIMA, would of course, also satisfy the requirements for this class.)

PERSONAL ATTRIBUTES NEEDED TO UNDERTAKE JOB

1. knowledge of medical terminology
2. knowledge of ICD-9 and CPT coding systems
3. analytical ability
4. mathematical ability
5. organizational ability
6. ability to interact with a variety of persons, including physicians and ancillary staff

Level II: Reimbursement Coding Specialist II 4840(3294)

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1 year of work experience comparable to Reimbursement Coding Specialist I

and

Certification as a Certified Coding Specialist (CCS) or Certified Coding Specialist—Physician based (CCS-P) or Registered Health Information Technologists (RHIT) or Registered Health Information Administrator (RHIA) by the American Health Information Management Association, or certification as a Certified Procedural Coder (CPC) or a Certified Procedural Coder-Hospital (CPC-H) by the American Academy of Professional Coders

PERSONAL ATTRIBUTES NEEDED TO UNDERTAKE JOB

1. possession of personal attributes listed for Reimbursement Coding Specialist I
2. skill in researching complex coding questions
3. ability to supervise others
4. ability to compose reports

Level III: Reimbursement Coding Specialist III 4841(2451)

CREDENTIALS TO BE VERIFIED BY PLACEMENT OFFICER

1. possession of experience/training required for Reimbursement Coding Specialist II
2. 2 years of work experience comparable to Reimbursement Coding Specialist II

PERSONAL ATTRIBUTES NEEDED TO UNDERTAKE JOB

1. possession of personal attributes listed for Reimbursement Coding Specialist II
2. proficiency in researching complex coding questions
3. ability to compose complex reports
4. ability to develop training programs and seminars

Reimbursement Coding Specialist I..... Revised
Reimbursement Coding Specialist II ..... Revised
Reimbursement Coding Specialist III..... Revised